OFFICE OF THE INSURANCE COMMISSIONER
STATE OF WEST VIRGINIA
COMPLAINT FORM

COMPLAINANTS NAME: _____

ADDRESS: _____

TELEPHONE #: _____

INSURED'S NAME: _____

CLAIMANT'S NAME (if different from the insured)**:** _____

INSURANCE COMPANY AND/OR AGENT: _____

TYPE OF COVERAGE: _____

POLICY #: _____

CLAIM #: _____

DATE OF LOSS: _____

THE REASON FOR YOUR COMPLAINT (EXPLAIN PROBLEM - Use other side of paper if necessary):

_____

_____

_____

_____

_____

_____

In order that this Department may properly process your complaint; it is necessary that you sign and date the following statement.

In addition, I hereby authorize any insurance company, or their representative, to make available to the West Virginia Insurance Department all medical and claim related data pertinent to this complaint. Said data to be retained by the WVIC or returned to the company supplying same, if requested.

_____ _____

(Signature) **(Date)**

Consumer Service Division
1124 Smith St., Room 309
Charleston, WV 25301

PO Box 50540
Charleston, WV 25305-0540
wvinscs@mail.wvnet.edu

(304) 558-3386 **Toll free in WV (800) 642-9004** **Fax No. (304) 558-4965**